Chapter 9

Cognitive-Behavioral Group Treatment for Disaster-Related PTSD

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The extreme and overwhelming forces of disaster often have far-reaching effects on individuals and communities. Though a disaster may last from seconds to several days, its effects may continue from months to years during the process of recovery and restoration. The lack of uniformity of methodology across studies coupled with the inherent difficulties in the study of disaster survivors, make it difficult to draw a definitive conclusion about the wide ranging prevalence rates of PTSD in disaster survivors reported in literature reviews (de Girolamo & McFarlane, 1996; Smith & North, 1993). The experiences of disaster survivors vary greatly, and it is likely that certain kinds of disaster-related experiences (e.g., bereavement, exposure to personal life threat, property loss) put victims at a higher risk for psychological problems (Bland, O'Leary, Farinaro, Jossa, & Revisau, 1996; Bromet, Parkinson, Schulberg, Dunn, & Gondek, 1982; Gleser, Green, & Winget, 1981; Goenjian et al., 1994; Green, Grace, & Gleser, 1985; Green et al., 1992; Keane, Pickett, Jepson, McCorkle, & Lowrey, 1994; Pfifer & Norris, 1989; Shore, Tatum, & Vollmer, 1986).

During the last decade there has been a remarkable development of disaster mental health services by federal, state, and local agencies, as well as by the American Red Cross and other nonprofit entities. Disaster mental health services are now often provided via on-site crisis intervention and immediate post-impact interventions such as defusing, debriefing, community education, and survivor advocacy (American National Red Cross, 1995; Myers, 1994; Young, Ford, Ruzek,

Friedman, & Gusman, 1998). Such services are preventive in nature and are intended to address normal responses to abnormal situations. They are not generally designed to treat symptoms of post-traumatic stress once they have developed into an established disorder. Despite receiving such preventive interventions, some survivors develop PTSD, and, of course, many of those exposed to disaster do not receive any intervention services. The practical tasks of recovery that require attention during the first weeks and months following disaster may also delay entry into treatment for many individuals who continue to experience high levels of distress. Moreover, many disaster victims do not seek mental health services despite having severe PTSD symptoms. For example, Young, Drescher, Kim-Goh, Suh, & Blake (1998) studied a sample of Korean-Americans following the 1992 Los Angeles Riot and found that the majority of individuals with diagnosable PTSD did not seek treatment (93% and 74% at the 4-month and 16-month intervals, respectively).

In sum, there may remain a significant treatment need among survivors after on-site crisis intervention and immediate post-impact interventions have been delivered. To meet these needs, states may apply for federally-funded crisis-counseling services for disaster victims.[1] Preliminary evidence with other types of trauma survivors indicates that relatively brief therapeutic intervention may reduce the chronicity of subsequent PTSD (Foa, Hearst-Ikeda, & Perry, 1995; Foa, Rothbaum, Riggs, & Murdock, 1991). Therefore, this chapter is an approach to providing time-limited integrative group treatment for disaster survivors who have developed PTSD. The chapter is organized into four sections. The first section outlines treatment objectives. The second presents the rationale for the procedural components selected in this treatment model. The third describes the procedures used, and the final section presents an outline of the 15 sessions of treatment.

GROUP TREATMENT FOR DISASTER-RELATED PTSD: OBJECTIVES

The primary objectives of a time-limited group treatment for disaster survivors are to:

[1]Governors of affected states may request a presidential declaration that federal assistance is needed to save lives and protect public health, safety, and property. Following such declarations, state departments of mental health are eligible to apply for funding through the Federal Emergency Management Agency's Immediate Service and Regular Service grants' crisis-counseling programs. If approved, these programs become survivors' primary resource for receiving disaster mental health services. The general objectives of the programs include restoring psychological and social functioning of individuals and the community, while limiting negative mental health outcomes associated with disasters (e.g., PTSD, depression, and substance abuse). The 15-session treatment described here can be delivered within the 9- to 15-month time of the crisis counseling programs.

- Screen prospective participants to specifically target diagnosed Acute Stress Disorder (ASD) or PTSD;
- Refer less severely symptomatic individuals for debriefing or education;
- Refer those diagnosed with other psychiatric problems to appropriate services;
- Reduce the frequency and severity of stress-related symptoms;
- Enhance survivors' control of symptoms of ASD or PTSD;
- Enhance problem-solving to address continuing disaster-related problems.

Treatment Components: Rationale

Most treatment approaches for PTSD include the remembering, describing, and cognitive-emotional integration of traumatic events, and the management of PTSD-related symptoms. In the model described here, several active ingredients of cognitive behavioral therapy for PTSD—trauma-scene identification, direct therapeutic exposure, cognitive restructuring, and self-management skills training—are integrated into a group treatment format. The rationale for each of these components and format is given below.

Group Treatment There are several potential benefits of treating disaster survivors in a group setting. First, many persons with PTSD believe they are alone in their experiences, and meeting and sharing stories with other survivors can reduce their feelings of isolation. Second, social support is an important aspect of coping with disaster, and a group provides a practical setting in which to ask for and give mutual support. Third, many individuals are reluctant to disclose details of their experience and reactions to it—a reluctance which may interfere with natural recovery processes. The group is a potentially useful vehicle for encouraging such disclosure through modeling. Finally, a group provides a helpful way for participants to learn about coping from other survivors dealing with often similar situations. Potential difficulties with the group format include the challenge to therapists to provide the right balance between the needs of individual members and the needs of the group as a whole, and the challenge of managing the emotional arousal of multiple participants at the same time. In order to facilitate these groups effectively, leaders require two sets of expertise and experience; background in trauma assessment and individual treatment for PTSD and in structured group work. It should be noted that, in some treatment settings, it may not be feasible to assemble suitable numbers of homogeneous disaster survivors to form a group, and that the approach described here may be modified and delivered in the context of individual treatment.

Direct Therapeutic Exposure From a cognitive-behavioral perspective, direct therapeutic exposure to significant elements of traumatic memories is necessary to reduce trauma-related fears and attain reduction of autonomic responses to related cues or reminders. It is especially important as a way of addressing aspects of PTSD symptomatology (e.g., hyperarousal, reexperiencing symptoms) which, elicited by trauma cues through classical conditioning, may be otherwise unresponsive to voluntary control. According to learning theory, fear reduction is accomplished in part via a process of extinction of fear stimuli through repeated exposure in the absence of aversive stimuli (Barlow, 1988).

The exposure process is also helpful in enabling participants to improve their ability to manage PTSD symptoms. Lyons (1991) noted that "individuals most likely to show long-term positive adjustment may be those who are able to reexperience their trauma with a relatively high degree of voluntary control, either on their own or with the aid of therapy, and who are willing to endure the discomfort of doing so" (p. 98). Horowitz (1993) suggested that trauma survivors who experience intense emotions gradually come to know "that these peaks will be followed by a reduction in intensity, making it possible to 'live through them'" (p. 53).

Direct therapeutic exposure is often an intense emotional experience and participants must be prepared accordingly. Preparation takes place both in pregroup orientation and screening sessions (on a one-to-one basis, often with one of the group leaders), as well as in the first group sessions (sessions one and two in this 15-session model). Preparation involves describing the exposure process and the participant's role in a manner that encourages optimistic but realistic expectancies about both the process and outcome of the procedure. Participants can also be helped to articulate their fears or reservations and encouraged to become actively involved in determining the timing, pacing, content, and intensity of exposure. Preparatory sessions also include a review of coping skills for managing symptoms and seeking social support. Direct therapeutic exposure should be delivered as part of a series of therapeutic interventions that proceeds from preparatory steps (including trauma education and stress management training) through the exposure work to relapse prevention (Keane, 1995).

Exposure may provide a means to reduce fear (and autonomic arousal) associated with trauma experiences, but of equal importance is its role as a platform for participants to process more complex thoughts and emotions that may perpetuate or exacerbate the core traumatic fear reaction. Through therapist-guided exposure, participants can be helped to reexamine their interpretations and conclusions about various aspects of the disaster experience, including issues related to hopelessness, helplessness, guilt, shame, grief, and rage.

Whether the hypothesized mechanism of change is habituation to traumatic stimuli, improvement in ability to cope with strong negative emotions, disconfirmation of trauma-related fears, or restructuring of distressing meanings, repeated exposure will usually be required to facilitate change. In the treatment outlined here, the major tool for ensuring repeated exposure is use of a "Self-Exposure Task" (Appendix 1), i.e., having participants listen several times (two to three times a week) to a tape recording of their trauma narrative.

Cognitive Restructuring Each individual exposed to trauma will likely experience a variety of distress-producing cognitions related to the event(s) which continue to cause significant levels of distress. For example, Horowitz (1981) analyzed the thematic content of intrusive thoughts and feelings in victims of personal injury and found that discomfort over vulnerability, rage at the source of injury, guilt over responsibility, fear of repetition, and discomfort over aggressive impulses were each present in over 50% of cases, while survivor guilt, sadness over loss, fear of similarity to the victim, rage at those exempted, and fear of loss of control over aggressive impulses were also common. In a discussion of the "coping narratives" of trauma survivors, Meichenbaum and Fitzpatrick (1993) proposed that

> persons who have problems adjusting to negative life events are likely to:
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> - make unfavorable comparisons between life as it is and as it might have been had the distressing event not occurred;
> - engage in comparisons between aspects of life after the stressful event, versus how it was before, and continually pine for what was lost;
> - see themselves as victims, with little expectation or hope that things will change or improve;
> - blame others for distress and fail to take on any personal responsibility;
> - fail to find any meaning or significance in the stressful event;
> - dwell on the negative implications of the stressful event;
> - see themselves as continually at risk or vulnerable to future stressful events;
> - feel unable to control the symptoms of distress (i.e., viewing intrusive images, nightmares, ruminations, psychic numbing, avoidance behaviors, hyperarousal, and exaggerated startle reactions as being uncontrollable and unpredictable);
> - remain vigilant to threats and obstacles. (p. 711)

Thoughts about PTSD symptoms may also be important to the etiology, maintenance, and treatment of PTSD. As Cioffi (1991) suggested in her discussion of somatic interpretation, people can be seen as "active self-diagnosticians" who "act on their internal representations of their illness and of their symptoms; that is, they respond to their private, subjective, sometimes idiosyncratic world of interrelated beliefs, fears, competencies, and goals" (p. 26). In line with such thinking, Meichenbaum and Fitzpatrick (1993) assert that "it is what survivors say to themselves and others about their intrusive thoughts, ruminations, and nightmares that figures most prominently in the adjustment process" (p. 711). For example, the disaster survivor whose intrusive images trigger a process of questioning of religious beliefs will have more problems than one who sees such symptoms in more benign terms, or, as Horowitz (1986) noted with regard to the intrusive images which may follow upon trauma, "these frightening experiences may lead to anticipatory anxiety about their recurrence or to secondary anxiety if the subject interprets the phenomenon as a sign of losing control or 'going crazy'" (p. 25).

Various authors have noted that it is especially important to process trauma-related information that is incompatible or inconsistent with existing beliefs. Tait and Silver (1989) contend "aspects of the existing system must be altered to accommodate the information, or the event must be reinterpreted in terms that are more assimilable" (p. 366). Roth and Cohen (1986) suggested that the violation of particular pre-trauma beliefs is especially likely to require extensive processing: there are schemata or principles that people have that prevent the uncomplicated assimilation of threatening material. This set of principles includes such basic concepts as: "I do not do bad things; I am intact and invulnerable; there is a just world; my world has meaning and coherence; and I am in control of my life" (p. 815). This same view is found in writers who focus on the "positive illusions" (Taylor, 1989) and "core assumptions" (Janoff-Bulman, 1992) challenged by traumatic events.

In outlining a theory of cognitive adaptation to threatening events, Taylor (1983) identified three major themes which are central to the cognitive readjustment process: "a search for meaning in the experience; an attempt to regain mastery over the event in particular and over one's life more generally; an effort to enhance one's self-esteem—to feel good about oneself again despite the personal setback" (p. 1161). Lifton (1979) described similar themes central to the major readjustment tasks of survivors: the need to reestablish a sense of belonging; the need to establish a sense of meaning to the event(s); the need to develop an orientation to the future.

Although each disaster survivor will be troubled by his or her own idiosyncratic negative thoughts, commonly held concerns addressed in the treatment approach are described here. These include thoughts and beliefs related to helplessness and fear, guilt (including survivor guilt), negative self-appraisal, anger

and rage at others (including organizations), loss, and ongoing/future implications of the disaster and PTSD symptoms.

- **Helplessness and fear**. Symptoms related to helplessness and fear are likely to be relatively "noncognitive"; that is they may be triggered by exposure to trauma reminders more or less automatically prior to conscious reflection. Fear may be understood as a result of classical conditioning, and as such, may not be under voluntary control and amenable to cognitive interventions. However, people also cognize about their feelings of helplessness and fear. They may consciously conclude, "It is dangerous to experience fear," or "I am helpless to protect myself should another disaster occur." These beliefs, in and of themselves, can add to the distress of survivors, and interfere with adaptive efforts at coping.

- **Guilt**. Beliefs related to guilt, self-blame, and shame are common in the aftermath of trauma and have been correlated with PTSD symptom severity (Kubany & Manke, 1995). When deaths have occurred, "survivor guilt" is common ("I should have died, and they should have lived"). Such beliefs may be especially distressing when survivors attribute the cause of a tragedy to something they did or did not do.

- **Negative self-appraisal**. Much of disaster-related cognition is concerned with the self. Horowitz (1993), for example, noted that "schemas that organize stressful information by the view that the self is bad, damaged, worthless, or incompetent" impede adaptive responding to stressful life events (p. 57). Trauma survivors often believe themselves to have failed, to be weak, or unworthy. Such negative self-appraisal may cause distress, depressed mood, social anxiety and isolation, or maladaptive coping.

- **Anger and rage**. Post-trauma thoughts may also focus on others: Other survivors, community members, rescue workers, organizations and authorities. Did others act appropriately? Were others responsible for the disaster or for some of its effects? What does the experience suggest about others in general, their trustworthiness, motivation, dangerousness? Such thoughts are clinically significant in that they can influence survivors' utilization of social support, their willingness to disclose disaster experiences, and their relationships in general.

- **Loss and ongoing/future implications of the disaster**. Obviously, many survivors suffer loss during and after disaster, including loss of family and friends, possessions or financial resources or both, home and community, jobs and personal roles, health, sense of safety and confidence in the future. Such losses place survivors at risk for chronic bereavement and psychosocial impairment. How do survivors make sense of their loss and their implications for the future? Thoughts regarding the implications of trauma are likely to be clinically important in recovery. Those who undergo traumatic disaster experiences are concerned with the loss of present and future interpersonal relationships, personal capacities, possessions, and access to rewarding activities (e.g., jobs, recreation). These actual and anticipated losses are likely to be the foci of much of the cognitive content processed by individuals as they attempt to come to terms with the event.

Self-Management Skills Training Helping individuals develop self-management skills to cope with the cardinal symptoms of PTSD (i.e., reexperiencing, behavioral avoidance/psychic numbing, and increased physiological arousal) is central to any treatment of PTSD. In the approach used here, relaxation skills training, attentional focus training, and active problem-focused coping are taught.

- **Relaxation skills training**. Relaxation training is a widely employed component of behavioral treatment for anxiety disorders. Several mechanisms of action have been posited to explain the beneficial effects of relaxation including decreased physiological arousal, reduced generalized anxiety, and improved information processing (Borkovec & Hu, 1990; Borkovec, Lyonfields, Wiser, & Deihl, 1993; Borkovec & Mathews, 1988; Clark, 1994).

Research on relaxation training in the treatment of PTSD has examined the relative effectiveness of various relaxation modalities such as muscle relaxation, deep breathing, thermal biofeedback (Watson, Tuorila, Vickers, Gearhart, & Mendez, 1997); use of relaxation as an adjunctive treatment component (Foa, Hearst-Ikeda, & Perry, 1995; Resick, Jordan, Girelli, Hulter, & Marhoefer-Dvorak, 1988; Silver, Brookes, & Obenchain, 1995); and its impact compared with other primary therapies, e.g., relaxation versus exposure + cognitive restructuring (Echeburua, De Corral, Zubizarreta, & Sarasua, 1997), relaxation versus cognitive restructuring + coping skills training (Echeburua, De Corral, Sarasua, & Zubizarreta, 1996), relaxation versus imaginal exposure and eye movement desensitization (Vaughn et al., 1994). The effects of relaxation have been positive. However, the various relaxation modalities appear to have limited therapeutic value when used alone and are perhaps best utilized in combination with other interventions.

Though reports of adverse affects associated with relaxation are rare, some individuals may experience an intolerable level of transient anxiety practicing relaxation (Borkovec & Heidi, 1980), and there has been a case report of dissociation induced by relaxation training in a combat veteran (Fitzgerald & Gonzalez, 1994). Assessing past adverse reactions to relaxation (imagery/hypnosis) interventions and tailoring the specific relaxation training approach to maximize each participant's sense of self-control are useful precautions.

- **Attentional focus training**. Experiential (Gendlin, 1996; Young, 1990), meditative (Vigne, 1997), and cognitive behavioral (Teasdale, Segal, Williams, & Mark, 1995) approaches to psychotherapy share an emphasis upon focused attention as a means of self-management. Attentional focusing involves shifting attention away from a preoccupation with global negative preoccupations (e.g., worry, self-doubt) to a specific focus on immediate bodily sensations, thoughts (positive affirmations), and feeling states. Consistent with this approach, social psychological and personality research indicates that mindfulness is associated with health (Langer, 1992), while self-consciousness (Saboonchi & Lundh, 1997) and thought suppression (Paulhus & Reid, 1991; Taylor & Brown, 1988; Wenzlaff, Wegner, &

Roper, 1988) are associated with a paradoxical increase in psychophysiologic problems and distress. In the present treatment, relaxation skills training, therapeutic exposure, and cognitive restructuring are all used as opportunities for practicing and reinforcement of attentional focusing skills.

- **Active problem-focused coping.** Research on coping processes has differentiated problem-focused and emotion-focused coping (Folkman & Lazarus, 1980). Coping responses which focus on problem-solving function to remedy the problem itself, while emotion-focused efforts attempt to lessen the negative emotions associated with the problem situation. Several studies with trauma survivors suggest that problem-focused coping is associated with better post-trauma outcomes (Nezu & Carnevale, 1987; Solomon, Mikulincer, & Avitzur, 1988; Solomon, Mikulincer, & Flum, 1988; Wolfe, Keane, Kaloupek, Mora, & Wine, 1993).

Facilitating active and self-enhancing coping can be accomplished by teaching a method of systematic problem-solving (D'Zurilla & Goldfried, 1971). Five steps of problem-solving can be applied to specific current psychosocial dilemmas troubling group participants: Problem definition, brainstorming, solution formulation, experimentation, and evaluation and return to further redefine the problem. This approach can stimulate group discussion about coping options and help participants learn from one another.

COGNITIVE-BEHAVIORAL GROUP TREATMENT FOR DISASTER-RELATED PTSD: 15-SESSION GROUP TREATMENT OUTLINE

Group Design and Session Sequence

We recommend that groups be composed of five to six members and led by two group leaders. Sessions require two hours and take place according to the schedule in the following outline:

Session 1. Introductions, Structure, and Group Rules/Disaster Experience: Similarities and Differences

Objectives

- Introduce group members.
- Explain check-in and check-out processes.
- Explain group goals, structure, and rules.
- Present rationale for group design and explain recovery process.

- Identify and examine members' expectations about recovery.
- Explore and acknowledge differences in disaster experiences.

Presentation/Procedures

1. Explain check-in process and conduct check-in.
2. Orient members to remaining components of Session 1.
3. Describe group structure.
4. Explain group rules.
5. Brief assessments of disaster experience.
6. Discuss similarities and differences in disaster experience.
7. Explain check-out process and conduct check-out.

Session 2. PTSD Education/Self-Management Skills Training

Objectives

- Provide basic PTSD information.
- Provide rationale for learning and using numerous coping strategies to manage PTSD symptoms during and after the group.
- Teach relaxation/attentional skills development and use of relaxation log.

Presentation/Procedures

1. Check-in.
2. Provide basic information about PTSD.
3. Discuss coping with PTSD and trauma-related emotions.
4. Self-management skills training: overview of coping strategies; relaxation and attentional focus training.
5. Check-out.

Session 3. Trauma Scene Identification

Objectives

- Identify coping strategies to be used to control or manage PTSD symptoms during and after the group.
- Help members practice self-management skills (relaxation and attentional focus).
- Identify and reduce fears regarding emotional and social consequences of disclosure.
- Review rationale for tape recording of trauma narrative and self-exposure task.
- Identify trauma scenes to be used during exposure sessions.

Presentation/Procedures

1. Check-in.
2. Self-management skills training: relaxation and attentional focus training.
3. Trauma Scene Identification.
4. Check-out.

Sessions 4–7. Disaster Trauma Memory Exposure (Direct Therapeutic Exposure)

Objectives

- Identify coping strategies to be used to control or manage PTSD symptoms during and after the group.
- Help members practice coping skills (relaxation and attentional focus).
- Ensure structured exposure to important trauma-related stimuli and memories, and prevent cognitive avoidance.
- Discuss emotional and cognitive reactions to the traumatic stories.
- Enhance perceived ability to cope with strong emotional experience.

Presentation/Procedures

1. Check-in.
2. Coping skills training: relaxation and attentional focus training.
1. Direct-therapeutic exposure.
2. Check-out.

Sessions 8–11. Negative Disaster–Related Thoughts (Cognitive Restructuring)

Objectives

- Identify coping strategies to be used to control or manage PTSD symptoms during and after the group.
- Help members practice coping skills (relaxation and attentional focus).
- Prompt discussion and analysis of distressing interpretations of the disaster experiences of members.
- Discuss alternative perspectives on their experiences.
- Distribute and review "Self-Talk Assignment and Affirmation Worksheet."

Presentation/Procedures

1. Check-in.
2. Self-management skills training: relaxation, attentional focus training (affirmation technique).
3. Present cognitive-restructuring sessions.
4. Check-out.

Session 12. Self-Management Skills Training: Affirmation Technique

Objectives

- Identify coping strategies to be used to control or manage PTSD symptoms during and after the group.

- Help members with final development of propositional phrase/affirmation.
- Help members choose markers for behavioral change.
- Teach members how to experience self talk, phrase/affirmation technique while in a state of relaxation.
- Discuss home practice of affirmation technique.

Presentation/Procedures

1. Check-in.
2. Self-management skills training: relaxation, attentional focus training (affirmation technique).
3. Check-out.

Sessions 13–14. Self-Management Skills Training: Problem-Solving about Continuing Disaster-Related Problems

Objectives

- Identify coping strategies to be used to control or manage PTSD symptoms during and after the group.
- Help members practice affirmation technique.
- Emphasize importance of active coping with disaster-related problems.
- Identify current disaster-related problems and help individuals anticipate future problems (e.g., anniversary reactions, reactions to similar weather conditions, holiday gatherings, etc.).
- Use group problem-solving to generate lists of ways of coping with ongoing disaster-related concerns.
- Prompt active coping efforts.

Presentation/Procedures

1. Check-in.

2. Self-management skills training: relaxation, attentional focus training (affirmation technique).

3. Present rationale for session.

4. Discuss ongoing disaster-related problems.

5. Use group problem-solving to generate lists of possible coping actions.

6. Choose coping actions for implementation.

7. Check-out.

Session 15. Summarization and Goodbyes

Objectives

- Discuss lessons learned and implications for the future.
- Identify and discuss feelings about group termination.

Presentation/Procedures

1. Check-in.

2. Presentation of rationale for current session.

3. Group member summarization of key lessons.

4. Discuss group ending.

5. Check-out.

DESCRIPTION OF PROCEDURES

Screening and Selection

A thorough individual screening of prospective group participants is necessary to ensure that individuals are appropriate for group membership. First, it is important to establish a diagnosis of PTSD to ensure that persons with more transient or less severe stress reactions receive less intensive assistance.

Second, it is important to perform a comprehensive assessment of treatment needs, so that problems outside the purview of this group treatment can be addressed. For example, disaster survivors seeking treatment may have been previously exposed to other traumatic events. In cases of traumatic reactivation, assessment necessarily requires differentiating between complicated and uncomplicated PTSD, and correspondingly, matching treatment needs with appropriate treatment modalities (Young, 1992). Also, some candidates for participation may be experiencing a variety of event-precipitated problems, including not only PTSD, but substance abuse, anger, depression, marital or family disturbance, and so on (Green et al., 1992). These problems may occur singly, but more often exist in combination. A broad assessment is therefore required to guide treatment selection, and a range of treatment modalities and procedures may be appropriate to the individual case (e.g., individual or group therapy, medications, anxiety management, couples or family therapy). Concurrent problems may suggest that group exposure treatment, even for those with established PTSD, will be contraindicated (Herman, 1992; Wahlberg, 1997). A medical examination is also recommended because the group work often elicits physiological arousal which may be inadvisable for prospective members with certain health problems (e.g., cardiac disorders).

Third, it is important to include individuals who have had broadly similar disaster experiences. For example, if group members have experienced only property losses, it is unlikely to be beneficial to include a person who has lost members of his or her family in the event. Moreover, the group described herein is not designed to be the primary or sole therapy for individuals who may benefit from family bereavement work (Shapiro, 1994) or who are in need of treatment for complicated mourning (Rando, 1993). Also, since there is relatively little time for cohesion building in this time-limited group, similarity of disaster experience can hasten group cohesion.

Finally, it is essential during the assessment and selection process to orient prospective participants to the group's rationale, structure, procedures, and objectives. Specifically, they should be informed that treatment will involve direct, possibly distressing, discussion of their traumatic experiences. This orientation can increase motivation to attend the group, minimize dropout, and help prepare members for treatment.

Introductions, Structure, and Group Rules: Procedures

The first session is designed to introduce members to one another and review the components, procedures, and rules of the group. The first group is structured as follows:

1. Explain check-in process and conduct check-in.

2. Orient members to remaining components of Session 1.

3. Describe group structure.

   Leaders introduce themselves and describe the design of the group: length, session content and sequencing, etc.

4. Explain group rules.

   Outline, explain, and answer questions about group rules.

   - Confidentiality: Members agree not to disclose the contents of discussion outside the confines of the group; therapists define limits to therapist confidentiality.

   - Showing of mutual respect among members of the group.

   - No pagers, cellphones, candy, food, or smoking.

   - No leaving the room (no bathroom breaks), unless break specified by group leaders.

5. Brief assessments of disaster experience.

   Leaders conduct a person-by-person structured brief assessment of the disaster experience of each member. Ask the following questions of each member: *"Where were you during the disaster?" "What happened to you that was painful or frightening?"*

6. Discuss similarities and differences in disaster experience.

   After restating the importance of communication of mutual respect and the avoidance of minimization of each other's disaster experience, leaders conduct a group discussion to explore similarities and differences in experience. Ask each participant the following: *"In what ways do you see your experiences as being similar to one another? And how about differences? How do you feel different, or what differences do you see between different persons' experiences?"*

7. Explain check-out process and conduct check-out.

The "Check-In/Check-Out" Process

An important component of each session is the check-in/check-out process. Sessions are structured to begin with a check-in process, proceed to the session's topic, and close with a check-out on the part of each member. The systematic process of checking-in provides group leaders with an opportunity to:

- Assess immediate emotional state of participants;
- Review coping efforts since last session;
- Identify issues which need attention prior to other therapeutic activities; and
- Repeat key therapeutic messages.

Similarly, a formal check-out provides one important means to:

- Encourage active participation by all group members;
- Individualize therapeutic learning; and
- Plan for between-session coping and support.

The check-in and check-out processes each require 10 to 20 minutes. Through check-in, each member is given an opportunity to say how he or she is doing, to describe his or her immediate ability to focus on treatment, and to discuss any issues which may cause distraction during the session.

Group members will often describe their current feelings, problems, or reactions to the previous session. To prompt appropriate reporting, leaders can give examples, e.g., highlighting exacerbation of PTSD symptoms such as depression, anger, or urges to drink or use drugs, as well as examples of effective coping. Members should be asked routinely to report on their efforts to cope with their emotions and problems between sessions. When the check-in process is first conducted, it is important that group members are given an explanation of its purpose and procedure—its rationale. This rationale must be described and then discussed with the group in the first session, and regularly repeated and summarized throughout the lifespan of the group. Through this process, members can learn how to make quick and effective use of the check-in routine.

A sample rationale might be:

> *"We're going to begin each session with a brief check-in so that you can tell us what's going on for you right now, how you're feeling at the moment, and your readiness to be in group today. Everybody brings something with them to group, and the check-in is a time when you can let us know what's on your mind so you can get feedback or help if you need it and so that you can begin to put aside other concerns to concentrate on what's going on here."*
>
> *"A goal of treatment is to assist you in coping with your worries and emotions so that they don't interfere with your day-to-day functioning. This check-in process is one way of helping you learn to do that."*

Following each session's topic, leaders conduct a check-out to end the session. Group members are helped to articulate what they learned about themselves in the session, and to make connections to their own trauma or life experiences. The process is also used to teach participants what to observe in themselves and to take responsibility for asking for support from others (as well as for giving support to others). Members might, for example, be asked: *"What feelings were brought up today?" "What can you do to care for yourselves between sessions?"*

Often, one or more participants will be upset at time of check-out, or concerned with particular issues. When necessary, leaders have the option of planning a coping intervention with these individuals, e.g., *"What can you do tonight, what can we do to help?"*

Coping, symptom management, and support plans can be arranged with input from group members, and group support can be mobilized. Other possibilities, including setting up verbal contracts or utilizing additional mental health services, can be considered. It is important that in the next session's check-in, group leaders follow up with the participant(s) usage of coping plans and the results obtained.

In sum, the check-in, check-out process and coping interventions are used to reinforce the alteration of automatic thoughts, emotional reactions, and impulsive behaviors by inviting members to think through first reactions and their consequences. Through the process of check-in and check-out, members are taught to self-monitor, use active coping, and take responsibility for using support.

PTSD Education Group members need to learn what constitutes PTSD and have realistic expectations regarding their recovery. In this session, group leaders give an overview of current perspectives on PTSD including the definition of traumatic stress, PTSD symptoms, factors associated with adaptation to disaster, forms of treatment, and treatment outcome.

Information about PTSD is important because it helps members to understand their symptoms and their reactions to the group. Group leaders should explore members' expectations of treatment outcome and the recovery process. Members should be prepared for possible short-term exacerbation of their PTSD symptoms during the group. Anticipatory guidance and help with coping strategies for symptom management provide reassuring therapeutic structure and safety to group members.

Coping with PTSD This topic extends the PTSD education discussion with a focus on how to increase and broaden the repertoire of participants' coping skills. A list of coping strategies (Appendix 2) is reviewed in the context of managing PTSD symptoms. Group leaders facilitate a discussion, asking participants to identify coping strategies they've used successfully in the past, as well as new strategies they are willing to try. Encouragement can be given to participants to partner-up with other members (for some coping activities, e.g., exercising, recreational activities) to increase and reinforce the benefits of social support. In addition, the first of several discussions about how negative thoughts about PTSD symptoms may impede recovery is undertaken. Participants are given Record of Coping forms (Appendix 3) to monitor symptoms, situations, negative thoughts, and coping efforts between sessions. During each session's Check-in process, members should use their completed Record of Coping forms to guide their report of coping attempts.

Self-Management Skills Training: Relaxation and Attentional Focus Skills Training Two methods of relaxation, progressive muscle relaxation (Bernstein & Borkovec, 1973) and conscious deep breathing (Young, 1990) are taught. Both procedures include a subset of instructions designed to facilitate attentional focus skills development. For example, during the progressive muscle relaxation procedure, in addition to the conventional instruction to focus attention on the experience of tension or relaxation in a specific muscle group, participants are explicitly instructed to re-focus attention on these physical sensations when they become aware that their attention has shifted. Consequently, participants practice how to focus and refocus their attention. The first self-management skills training session is structured as follows:

1. Present rationale for learning several strategies for coping with PTSD related symptoms. A sample rationale might be:

   "As we previously discussed, PTSD affects many aspects of your life and requires more than one stress management strategy to cope with its various symptoms. After each session's check-in, we will devote 15 to 20 minutes to learning and practicing different coping strategies and skills that can be applied to managing your PTSD-related symptoms. In addi-

tion, we will give you homework assignments to complete between sessions to build upon the coping skills you are learning here or perhaps already use."

2. Give rationale for techniques. A sample rationale might be:

"For the remainder of today's session, we would like for you to begin learning how to experience relaxation while increasing your ability to focus your attention. In later sessions you will learn how to combine and apply these skills to develop positive thoughts that counter negative thinking. We also examine several other problem-solving and stress management strategies."

"A common component of many PTSD treatments is teaching various relaxation techniques. One helpful and easy-to-learn technique is progressive muscle relaxation. We modify it slightly to show you how to focus and refocus your attention. Eventually, you will learn how to apply the skill of attentional focus on positive thoughts while in a state of relaxation."

3. Discuss technique and overview of process. A sample introduction and overview might be:

"Today, we will begin with the modified muscle relaxation technique. For the next two sessions, you will learn and practice this technique here and at home. Three weeks from today, we will learn a conscious deep breathing technique that also induces relaxation and helps develop your ability to focus your attention. You will have to practice these techniques daily between our sessions to learn them quickly. We will give you handouts [leaders must prepare a handout describing procedure; use description presented below as a template] *and a log* ["Relaxation Log," Appendix 4] *for monitoring whether or not these techniques are helping you to experience relaxation. In future sessions we will have more in-depth discussions about disaster-related thoughts and you will receive a written assignment to complete* ["Self-Talk Affirmation Technique Worksheet," Appendix 5]. *This assignment builds on the work done in the session and will help you identify negative disaster thoughts and alternative positive thoughts or self-talk. In our last few sessions together, we will practice how to combine relaxation, focused attention, and self-talk to increase your ability to counter negative disaster-related thoughts."*

"Before we begin, we would like you to fill out a log that records your current level of tension/relaxation, so that we have it to compare to your level after the relaxation procedure and after several weeks of training. Please fill out this log daily, before and after you practice the relaxation procedures at home."

4. Facilitate modified progressive muscle relaxation procedure. A sample instruction narrative might be:

"The progressive muscle relaxation procedure is simple. With my guidance you will carefully tighten and relax various muscle groups in your body. As you tighten the muscle group, please focus your entire attention on the experience of tension in those muscles. Make the sensation the entire focus of your attention. As you relax, again focus all your attention on the sensations you experience in that muscle group. You can expect that your attention will shift. This is natural. When you become aware that your attention has shifted, use this as a signal to remind you to refocus on the current muscle group. Avoid any criticism of yourself when you have noticed that your attention has shifted. The key is to bring your attention back each time you notice it has shifted without any additional interference. I will periodically remind you to refocus your attention. Please sit comfortably, but not in a position that is likely to cause you to fall asleep, and adjust your clothing and take off eyeglasses, as we prepare to start. Any questions?"

"Let's begin. Starting with your head and working your way down to your feet, observe any sensations you have in your body. Simply observe where your body is holding tension and where it is relaxed. Write down on the relaxation log, using the triangle to indicate "before"—the corresponding level of relaxation or tension that you feel. Now lets begin with the first step. You may wish to close your eyes, but if you feel uncomfortable doing so, find a spot in front of you to look at. As we move through the different muscle groups, do not do anything that might aggravate any medical condition you may have. Simply skip that muscle group."

"Please tighten your right foot (pointing toes away from your body), focusing your entire attention on the experience/sensations of tension in your right foot. Tighten the muscles in your foot hard as you can without causing cramping. Hold the tension. If you begin to think about something else, simply bring your attention back to the sensations in your right foot. Hold the tension for two more seconds."

"Now relax the right foot, paying attention to the change in sensations. Once again, if your mind has wandered, bring it back to the sensations in your right foot without any self-criticism or other thought. Repeat tightening your right foot."

Leader continues with the protocol outlined below, periodically reminding members to refocus their attention. Each muscle contraction (tension) is completed in approximately three to four seconds. Each release of the contraction (relaxation) is completed in five to six seconds. The instruction narrative continues as follows:

- *Tighten right calf (straighten leg and point toes toward your body). Relax. Repeat.*
- *Tighten right thigh (straighten leg and contract thigh muscles). Relax. Repeat.*
- *Deep full inhalation, full exhalation.*
- *Tighten left foot (straighten leg and point toes away from your body). Relax. Repeat.*
- *Tighten left calf (straighten leg and point toes toward your body). Relax. Repeat.*
- *Tighten left thigh (straighten leg and contract thigh muscles). Relax. Repeat.*
- *Deep full inhalation, full exhalation.*
- *Tighten buttocks. Relax. Repeat.*
- *Tighten stomach (bring stomach in towards spine). Relax. Repeat.*
- *Tighten chest (squeezing shoulders together). Relax. Repeat.*
- *Deep full inhalation, full exhalation.*
- *Tighten shoulders and neck (raise shoulders toward your ears). Relax. Repeat.*
- *Slowly bring right ear toward right shoulder left ear toward left shoulder chin toward chest, return to normal position. Repeat.*
- *Deep full inhalation, full exhalation.*
- *Tighten jaw. Relax. Repeat.*
- *Tighten nose. Relax. Repeat.*
- *Tighten eyes gently. Relax. Repeat.*
- *Tighten forehead (raise eyebrows toward ceiling). Relax. Repeat.*
- *Deep full inhalation, full exhalation.*
- *Tighten right hand (make fist as if squeezing a rubber ball). Relax. Repeat.*
- *Tighten right forearm (straighten arm, lock elbow, and bend wrist backwards). Relax. Repeat.*

- *Tighten right upper arm (bend elbow, tightening bicep, like you were Popeye). Relax. Repeat.*

- *Deep full inhalation, full exhalation.*

- *Tighten left hand (make fist as if squeezing a rubber ball). Relax. Repeat.*

- *Tighten left forearm (straighten arm, lock elbow, and bend wrist backwards). Relax. Repeat.*

- *Tighten left upper arm (bend elbow, tightening bicep, like you were Popeye). Relax. Repeat.*

- *Deep full inhalation, full exhalation.*

"Okay, when you feel ready, orient yourself to the room. What was the exercise like for you? Does anyone have any questions? Record on the relaxation log, using the plus sign to indicate "after," the corresponding level of relaxation or tension that you feel. Did anyone's tension increase?"

In subsequent sessions, leaders can collapse muscle groups to abbreviate the procedure (e.g., "tighten feet, lower legs, and thighs simultaneously"), checking to see if members are able to reach significant levels of relaxation with the shortened process. Members are more likely to maintain practice at home if they can learn how to experience relaxation in less time.

The *conscious deep breathing technique* is structured as follows:

1. Review guidelines for technique:

   - Each repetition of inhalation and exhalation is done slowly and quietly (*"Another person should not be able to hear your breathing."*).

   - Each inhalation and exhalation is executed for as long as possible without discomfort while the primary focus of attention is on the sensation of breathing in and out.

   - There are four steps and each step is repeated three times. Members are instructed to keep track of each step and repetition. A useful method of tracking is to begin with the thumb placed on the lowest of the three sections of the index finger. For each repetition, the thumb is moved one section upward. For each successive step, the corresponding successive finger is used until the thumb has reached the top section of the "pinky."

2. Ask members to record level of relaxation or tension on relaxation log.

3. Ask members to sit comfortably and close eyes. Members who wish to keep eyes open are asked to focus attention on a spot in front of them. Begin guiding members through the four steps.

   - Inhale through nose. Hold two seconds. Exhale through nose.

     (Thumb on index finger.) Repeat twice.

   - Inhale through nose. Hold two seconds. Exhale through mouth.

     (Thumb on middle finger.) Repeat twice.

   - Inhale through mouth. Hold two seconds. Exhale through nose.

     (Thumb on ring finger.) Repeat twice.

   - Inhale through mouth. Hold two seconds. Exhale through mouth.

     (Thumb on pinky.) Repeat twice.

4. Ask members to resume their natural form of breathing and to reorient to the room. Inquire about members' experiences and invite questions. Ask members to record level of relaxation or tension on relaxation log. Ask if anyone's level of tension increased.

Self-Talk Affirmation Technique

After the session about negative disaster-related thoughts and counterarguments, a homework assignment, Self-Talk Affirmation Technique Worksheet (Appendix 4), is given in preparation for learning an additional attentional focus modality, referred to as an affirmation technique (Young, 1990). The affirmation technique is an integration of the relaxation, attentional focus, and the cognitive restructuring work previously practiced by group members and is similar to the popular relaxation-response technique described by Benson (1975), with one important modification. Instead of choosing one word, the individual substitutes a propositional phrase (an affirmation) developed from the Self-Talk and Affirmation Technique Worksheet.

The affirmation technique is designed to teach participants how to focus and refocus their attention on the propositional phrase or affirmation while in a state of deep relaxation. Each phrase or affirmation may be divided into two or three

sections. If divided into two sections, the first part of the phrase or affirmation becomes the subject of thought during an extended inhalation. The inhalation is followed by a 2- or 3-second holding of the breath. The second half of the phrase or affirmation is the subject of thought during an extended exhalation. If divided into three sections, the phrase or affirmation is divided to correspond with the inhalation, holding of breath, and exhalation. An example of how to divide a propositional phrase or affirmation to correspond to the cycle of breathing is given below:

Example propositional phrase/affirmation:

"I can control my anger, I can choose how to express it."

Dividing phrase in two sections:

Inhalation	**2-second hold**	**Exhalation**
"I can control my anger"		"I can choose how to express it"

Dividing phrase/affirmation into three sections:

Inhalation	**2-second hold**	**Exhalation**
"I can	control my anger.	I can choose how to express it"

Applying the attentional focus skills learned while practicing the progressive muscle and conscious breathing techniques, members are taught how to practice focusing and refocusing their attention on the phrase. The procedure for the affirmation technique is structured as follows:

1. Group leader facilitates an abbreviated version of the progressive muscle relaxation and conscious breathing procedures.

2. Maintaining the relaxed atmosphere, group leader asks members to begin focusing their attention on their individual phrase while taking in a deep and extended inhalation.

3. Instructions are given to continue focused attention on the affirmation while holding and exhaling the breath. Instructions are repeated several times. Members are then given a few minutes to continue the procedure on their own. Periodically, the group leader reminds members to bring their attention back to their affirmation without any other self talk, e.g., *"Your attention may have wandered, that's okay, simply bring it back to the affirmation and avoid telling yourself 'Oh, my mind wandered, I'm not good at this.'"* The group leader continues to alternate between in-

structing members to repeat the procedure on their own and giving them explicit instructions to refocus. The entire protocol runs for 10 minutes.

Note, that in the course of reviewing the Self-Talk and Affirmation Assignment group leaders will be required to use clinical judgment to evaluate if any of these propositions are an expression of negative or distorted styles of thinking (Burns, 1980), or unrealistic expectations, (e.g., "I shouldn't let things bother me." "I shouldn't be nervous."). Group time can be used to help members modify affirmations so that they represent a realistic or helpful cognitive adaptation (e.g., "When something bothers me, I can help myself." "I can practice and experience relaxation.").

Members are instructed how to practice each of the procedures at home and given handouts as guidelines. Daily home practice is essential to members' acquiring and maintaining the self-management skills of relaxation, attentional focus, and self-talk/affirmation.

Self-Management Skills Training: Active-Problem Focused Coping Many disaster-related problems (e.g., loss of resources, disaster aid procedures, rebuilding issues) continue long past the initial period of acute recovery and continue to cause distress for the survivor. How the individual copes with these challenges is one influence on long term outcome. So, it is important to encourage active adaptive coping.

Group leader may begin with the following rationale:

> *"During our past meetings, we've focused on your trauma memories and disaster-related thoughts. In this session, we want to focus on the role of active coping. Some problems caused by the disaster are not easily solvable and will continue to challenge your abilities to cope. It is important that you take an active approach to coping."*

> *"You may have had limited responsibility for events due to lack of control over the behavior of others, the stress and confusion of disaster, limited availability of information, and so on. Similarly, you cannot be held responsible and blamed for your emotional reactions to the disaster and your PTSD symptoms. But, you are responsible now for taking action toward recovery from PTSD and toward active coping with problems."*

The group is asked to generate a list of problems caused by the disaster which cause continuing difficulties. Examples include:

- Pain or disability due to injury

- Financial problems
- Unemployment
- Homelessness
- Legal processes
- Problems with disaster relief applications

In sessions 12 and 13, one significant ongoing problem faced by each group member is taken as the topic of discussion, and the group helps identify coping actions. Focusing on one individual at a time, the group helps the individual generate possible coping actions. The person is then helped by the leader, with input from the group, to problem solve in order to identify actions that seem most useful as well as to determine how to begin to implement them prior to next session.

Immediately after the group has identified a list of coping actions for the individual's problem, the member should be asked to select several of the actions for implementation. He or she should be asked to identify which actions will be put into practice and asked to report on the experience at the next session. Each member should complete this problem solving exercise at least once in this two-session block.

Trauma Scene Identification It is important to acknowledge and address fears of recalling a trauma scene and disclosing the associated details and emotions. The fear of losing emotional control may cause some group members to omit upsetting elements, minimize events, avoid details during the recounting of memories, or use language which distorts their emotions (e.g., "He left us," versus "He was blown apart."). Fear of not being able to stop crying, not receiving support, of going crazy or going off and becoming violent is common. The therapists can speak directly to these concerns and give realistic reassurance regarding them.

Detail and emotionality of trauma stories are also influenced by social factors. Participants may be concerned about the social acceptability of their actions and expect negative responses to them. They may have encountered real or imagined condemnation by those they previously spoke to, or others who may not have wanted to hear their stories. In group, participants could omit or modify details out of fear of pushing others away, or they might not reveal the intensity of their emotions out of a lack of trust or dislike of certain members. Issues related to actual and expected reactions of members, as well as trust and disliking should be discussed.

Trauma scene identification sessions are structured as follows:

1. Provide rationale for recalling trauma scene.

2. Conduct a discussion about fears of thinking about and disclosing details of trauma.

   "Many people who participate in counseling groups are anxious about what will happen if they talk about their traumatic experiences, what will happen with their emotions, and how will other people react to hearing their stories? What concerns each of you about opening yourself up and telling your stories?"

3. Leaders ask questions to prompt discussion of the following common concerns:

   - Loss of control
   - Increased emotional pain
   - Inability to stop crying
   - Rejection or condemnation by others

   During the discussion, leaders interject information about other potential emotional reactions (e.g., rage, guilt, helplessness) reassuring members of their normalcy and that, although the feelings may be frightening, they can be dealt with in a new manner without negative consequences. Other common reactions members should be prepared to possibly experience and manage include:

   - Presence of physical symptoms
   - Amnesia for some past traumatic events
   - Increased dreaming
   - Increased thoughts about alcohol/drugs
   - Reactivation of strong emotions linked to prior traumatic events

4. Leaders review rationale for tape recording of trauma narrative and self-exposure task.

   "We understand it's upsetting to think about disaster experiences, but we know from our work and clinical research that as survivors recount their

experiences, they begin to cope more effectively with their memories and emotions. Part of treatment involves reviewing your experiences enough times so that you feel less fear and pain when doing so. As we discussed in the pregroup meeting, a tape recording of your trauma narrative is made for your use and is an important tool in your recovery. With the aid of the work we do here, frequently listening to the tape will enable you to practice techniques to cope with distressful feelings and thoughts effectively. There are several options for when and how to use the tape. We want you to use the tape when you feel ready to do so. When you feel ready, you can listen to the tape on the day of a group meeting, sometime before session; you can listen alone or in the presence of a trusted friend or family member. The tape remains in your possession and you are in control of using it for this part of your recovery."

5. Leaders help members to identify disaster-related traumatic scenes.

Direct Therapeutic Exposure Exposure sessions are conducted one member at a time, with two participants given guided exposure each session. Group leaders meet to select the order in which individuals are to describe their traumatic experiences. Clinical judgment is the basis for these decisions, and criteria for selection can include evaluating participants' current emotional state and their relative ability to model the procedure in terms of providing an emotionally-congruent narrative, demonstrating relatively effective coping skills, and receptivity to suggestion.

Each participant is given one in-session opportunity to describe his or her chosen traumatic disaster experiences. Leaders should generally respect participants' choices, while encouraging them to select emotionally significant experiences. The Self-Exposure Task occurs between sessions, when members are asked to listen several more times (usually 2 to 3 times a week) to the tape recording of their trauma narrative. Group leaders must ensure successful recording of the in-session narrative. To maintain confidentiality, the recorded segment should only include the member's trauma narrative and accompanying therapists' remarks, and not the postnarrative group discussion. The Direct Therapeutic Exposure is structured as follows:

1. Check-in.

2. Describe the task.

   Tell group members it is their task to talk about their most upsetting or important traumatic experiences during the disaster, including details of what they saw, heard, and experienced, and their thoughts, feelings, and sensations during the experience.

"We would like you to describe, in detail, a significant, upsetting disaster-related experience. It's important to use today's time to cover the things most troubling and painful to you, and not avoid telling us about things you feel ashamed, guilty, or embarrassed about. We want to support and help you take the risks of sharing and acknowledging what happened. We want to know what you saw, heard, and felt, and what you were thinking and feeling at the time. I will be guiding you to focus on different parts of the experience and to remember details. Please share as much as you can, but what you share is your choice at all times."

"The most important memories to discuss are ones that continue to cause you distress and interfere with your daily life. These memories may be related to events and experiences that you think about often, or that show up in your dreams. They might have to do with strong emotions like guilt, shame, terror, helplessness, grief, or sadness. They might be related to powerful and disturbing images of things you witnessed or experienced."

"I will also be asking you how you're feeling as you tell your story. We don't want you to be overwhelmed, but we do want you to be able to acknowledge to yourself and the group any painful feelings that arise."

"... (co-therapist) will be following along but will be watching the group as a whole to monitor, and if necessary, respond to other members' reactions to your account. We will attempt to preserve your time so that you don't lose your focus. Consequently, if any one of you listening have a strong reaction, we will most likely ask you to remember it, and bring it up after _____ (narrator) is finished."

3. Identification of members/selection of disaster experiences.

   Tell the group which members have been selected to tell their disaster stories. Ask the first person to briefly identify the traumatic experience he or she has selected.

   "We realize that you may have experienced a number of frightening or upsetting experiences during _____. Please tell us which particular experience you decided to focus on today, and why you've made that choice."

4. Begin tape recording.

5. Begin the trauma account.

   The course of the narrative should include details of the experience, the identification of thoughts experienced during and after the trauma, and expression of emotion during the narrative.

"Okay _____, are you ready to begin? You selected _____ as your first scene, so please begin with telling us what happened and what your feelings and thoughts were as it was happening."

Allow the survivor to use his or her own words. When necessary, use questions to encourage elaboration of statements, seek clarification, or interpretation of events. Often, survivors have told a version of their experience several times before having sought treatment. Generally, these accounts neglect important details. Enrich the context of memory retrieval by selectively asking questions about moment-to-moment details of places and events.

If the emotional tone of their story is flat, ask questions about feelings to increase the emotionality of the account. If the narrator becomes silent, ask:

"What are you remembering?" "What are you thinking or feeling right now?"

Whenever possible, let him or her know why you are asking the question:

"I saw a look on your face and wondered if you were having some strong feelings about that."

As the story unfolds, care should be taken to ensure the narrator does not avoid important aspects of the experience. To minimize avoidance and ensure attention to important issues, ask questions about:

- Bodily/mental reactions (e.g., freezing, shaking, confusion, sense that things were not real, sense of seeing events from a distance).

"What are you feeling in your body right now?" "What are you saying to yourself right now?"

- Feelings of fear, panic, sadness, anger.

"Can you pay attention to, and stay with, what you're feeling right now?"

- Thoughts and feelings about bodily reactions and emotional feelings.

"What are you saying to yourself about what's happening, or about how you're feeling?"

Throughout these sessions, the leader who is not guiding the narrator monitors responses of group members who are hearing the story. It is important to inquire about members who begin crying or appear to be experiencing other strong emotions during the story. Bearing in mind that continuity of narration is important, a clinical judgment is necessary regarding the allotment of time attending to a member who demonstrably reacts. Often, it will suffice to say, for example:

"John, I can see that you had a strong reaction to Jane's experience. Pay attention to what caused you to react strongly so that we can talk about it after Jane is finished."

Members are also monitored for signs of tuning out or dissociation. Those who do so can be brought back to the present by reminding them of the importance of listening to the narrator, conveying your interest in their reaction, and letting them know that after the account is completed, you will be asking them about what happened. In extreme cases, using a warm but firm tone, instruct the individual to look at a timepiece and tell you the time, or verbally orient him or her to the room, date, time, and the safety of the situation, for example:

"Tom, you are sitting here with us in the county building, its Wednesday, July 3, 7:45 p.m., and you're safe here. Repeat to me what I just said."

Return to the narration as soon as possible and upon its completion, ask the member who dissociated:

"Where are you right now?" "Where did you go before?" "Did you have trouble relating to what _____ was saying?"

6. Ask about additional trauma-related themes.

After the disaster event or experience has been described in some detail from start to finish, it will be helpful to briefly ask about other disaster-related themes, if they have not been mentioned earlier.

- Perceived consequences of actions (e.g., others suffered or died).
- Reactions of others (e.g., viewed negatively by others, avoided by them).
- Impact on self-image and self-esteem.
- Sense of betrayal by God, authorities, or others (e.g., random senseless destruction; public relation spins; relief procedure obstacles;

poor leadership; inadequate preparation or information). For example, many migrant victims of the 1985 Mexico City earthquake who later were victimized by 1989 Loma Prieta earthquake, believed they were deservedly being punished by God.

7. Stop tape recording.

8. Ask about reactions to telling about traumatic disaster experiences (do not record).

   Be vigilant for shame, guilt, concern about reactions of other group members, anger, fears about continuing emotional upset and worsened PTSD symptoms. Explore specific negative reactions to disclosure if it seems appropriate.

   "You've just told us about some very painful and upsetting experiences. How do you feel about having gone through all this with us?"

   "During some of our first meetings in this group, we discussed some of the fears that people might have about telling their stories, fears about breaking down emotionally, shame, negative reactions of others, and so on. What concerns do you have about what you've been saying today?"

9. Invite other group members to comment.

   Invite group members to share their feedback and observations with the individual who has described his or her disaster experiences. After their comments, ask them:

   "What did you learn for yourself today?"

10. Ask next member to begin disaster account and begin tape recording (new tape). Repeat process as outlined above.

11. Prepare members to cope between sessions.

    Ask members to anticipate how they will be feeling and reacting immediately following the group and through the following days. Help them develop coping plans for the time between sessions. Focus on members who have recounted their experiences, but attend to needs of other members as well.

    Ask members about coping:

    "How did you deal with what happened immediately following the events?"

"What did you do to cope with your feelings about what had happened?"
"What have you done in the past to cope successfully with difficult situations or problems?"

Ask about the following potential reactions:

- Shutting down
- Isolating /keeping others away
- Alcohol/drug abuse
- Denying importance of the events
- Anger /aggression/retaliation
- Exaggerated sense of responsibility for others

"You've done some difficult things here today. You've described painful memories and identified how you've coped in the past; you've received feedback from each other. As we've discussed before, your PTSD symptoms are likely to be strong now because you have willingly opened yourself to the memories and not avoided all your painful thoughts and feelings.

"Now is the important time for you to work at developing a new style of coping with your memories and symptoms. This will be hard, but it's very important. What are you willing to do to deal with your distress between now and our next meeting?"

"How can we help as a group?"

"What are the other members of the group willing to do to support ... as he/she works toward more positive ways of coping?"

12. Assign self-exposure task.

During exposure sessions, every member of the group will have one opportunity to recount his or her traumatic disaster experience. However, such traumatic exposure should be repeated in order to increase the likelihood of therapeutic benefits. Repetition of exposure is achieved via a self-exposure task.

Once again, leaders present rationale for repeated exposure and facilitate discussion about the self-exposure component of treatment.

"As you know, we've made a tape recording for you to listen to and think about. It will help you digest everything that we talked about. Remember, the tape is intended to serve as a tool in your recovery. By listening to it a number of times, you can begin to learn to effectively manage the feelings and distressing thoughts it brings up. We want you to do this when you feel ready. You are in control of this part of your recovery."

To minimize negative reactions to initial efforts, the survivor should arrange for some form of social support immediately after self-exposure. Remind members of their options for when and how to use the tape:

- Listen to the tape on the day of the next group meeting, in the morning or afternoon before the session.

- Listen to the tape in the presence of a trusted friend or family member who was not a victim of the disaster.

Group leaders identify when and under what conditions the individuals in the group plan to listen to their tape, and explain the Self-Exposure Task Record (Appendix 5).

13. Check-out.

Cognitive Restructuring The accounts of trauma lead therapists to identify negative, distorted interpretations of the events which perpetuate distress and prevent recovery. Questions of culpability, predictability, and controllability of traumatic events are important because inappropriate self- or other-blame may cause intense feelings of guilt and anger that exacerbate distress, depression, and PTSD symptomatology.

Negative beliefs related to disaster experiences sometimes perpetuate distress and may prevent recovery. It is important to address these distressing understandings, and help the survivor find more constructive perspectives on his or her experience. In these sessions, therapists raise core themes (related to common negative disaster-related thoughts) for consideration and discussion within the group. The accounts of trauma generated in earlier sessions will help identify particular beliefs causing distress for specific group members.

Recommended content for Sessions 8 to 11:

Session 8. Helplessness and fear.

Session 9. Guilt and thoughts about self.

Session 10. Anger and rage.

Session 11. Loss and ongoing/future implications of the disaster and its effects.

To manage effective discussion of these themes, group leaders must anticipate the kinds of negative interpretations and conclusions drawn by members, and develop an effective repertoire of counterarguments or self-statements and beliefs which present alternative, more forgiving interpretations of events. Some common disaster-related negative thoughts and possible counterarguments, grouped by theme, are presented in Table 9.1.

The procedure for cognitive restructuring is as follows:

1. Present rationale for cognitive-restructuring sessions.

   Give rationale for reviewing some of the attitudes and beliefs about disaster that continue to cause problems, and for the intention of finding ways for members to feel less distress.

   "We've talked a lot about some very traumatic things that happened to you all. Now we want to help you take a look at some of your interpretations about what happened as well as the conclusions that you drew from your experience. Maybe we can help you find some new and less distressing ways to think about what happened."

2. Outline key disaster theme.

   Outline the current theme and its relationship to disaster-related traumatic experience. Make reference where possible (based on knowledge gained during previous sessions) to examples of the current theme as it applies to members, (e.g., guilt).

   "For example, John, you shared with us in an earlier session that you felt you made the wrong decision by not following evacuation orders which, in turn, resulted in the severe injury of your son. As I understand you, this belief that you are responsible for his injury and cannot be forgiven continues to cause you much distress."

3. Lead discussion of theme.

   "Today, lets talk about this theme of (guilt) following disaster. What thoughts and feelings do you have about blame and guilt?"

TABLE 9.1 Common Disaster-Related Negative Thoughts and Possible Counterarguments

Theme	Negative Thoughts	Counterarguments
Helplessness & fear.	I was helpless then, and I won't be able to cope with future events either.	I may have felt helpless, but my actions saved my life, and I can continue to help myself.
	It's unacceptable to experience fear like this.	Fear is natural and helped me to survive. Gradually, I can ease out of it.
	The world is an extremely dangerous place and I must be constantly on guard to protect myself.	There are times that I need to be on guard and times that I don't. I don't always have to be on guard.
	My kids will never be safe again.	Everything in reason is/has been done to keep my kids safe.
	My kids will be scarred for life.	Other kids heal from loss and so can mine.
Guilt & thoughts about self.	Because of me, other people died; I should have prevented their deaths.	Many factors beyond my control resulted in the deaths that occurred.
	I was a coward.	I felt afraid, but my actions kept me from further injury.
	I should have helped my neighbor.	Stopping could have caused greater problems.
	I should have had emergency supplies on hand.	The disaster could have destroyed all supplies. I was creative with the supplies I had.
	There's something wrong with me; I should have gotten over this by now.	It takes time and patience to get over this. I'm not the only one going through this.
Anger & rage.	Other people can't be trusted to help.	There are people who can/will help me, and there are people who can't or won't.

Table 9.1 continues on page 186.

TABLE 9.1 Continued

Theme	Negative Thoughts	Counterarguments
	The authorities are only interested in saving money.	It is difficult to apply for relief, but persistence and building a strong case is my best defense.
	If the inspections were done, this wouldn't have happened.	I feel angry about their negligence and I am going to do what I can to see that it doesn't happen again.
Loss and ongoing/future implications of disaster and PTSD symptoms	I'll never get over this; it'll ruin my life.	People rebuild their lives. Each week I can do something to make my life better.

After acquiring examples of guilt-related thinking, therapists gradually move into the process of helping members challenge their self-blame.

4. Help members challenge or reframe negative beliefs and conclusions.

While acknowledging how painful certain beliefs are, therapists help participants challenge the validity (accuracy and completeness) of some trauma-related conclusions. It is important to use group feedback to provide more positive alternative interpretations of events. This process often naturally produces empathic comments from members as they help one another see things from new perspectives. During the discussion, it is useful if one of the therapists lists counterarguments (e.g., reasons why guilt is unwarranted or exaggerated) on a flip chart or board. Therapists will need to be creative in prompting members to identify alternative perspectives or counterarguments. Therapists can ask leading questions:

"Should you accept sole responsibility for what happened?"

Or, restate the negative belief in exaggerated form:

"You should have been perfect in the way you handled the situation!"

The exaggeration can give attention to parts of the belief that are open to challenge. One way to generate additional counterbeliefs is to ask group members the following questions:

"If this had happened to a friend or family member, what would you say to him?" or *"What would you think of her?"* or, *"If you had been injured instead of him, would you have wanted him to feel guilty about your injury?"*

Often, given the conditions under which the disaster occurred, group members could not have predicted or controlled events and therefore cannot reasonably assume blame for their occurrence. Williams (1987) listed several useful ways to help those suffering from survivor guilt to realize they did the best they could under the circumstances:

- Drawing attention to the limited time during which decisions were taken, the amount of experience they had in such decision-making situations, and the amount of information they had at the time;
- Investigating whether others shared some of the responsibility for decisions, by direct action or the approval of action;
- Identifying as many positive aspects as possible of the person's behavior during the trauma.

5. Lead reflection on implications of discussion.

Ask the group, and especially the members most troubled by the theme under discussion, how the considerations generated during the discussion fit with their negative beliefs:

"Looking back on things, several people here have acknowledged that they made a decision which was understandable given what they knew at the time. How does that fit with some of you blaming yourselves for making a bad decision?"

Therapists can summarize parts of the discussion and describe aspects of the disaster experience that don't fit with the belief as it applies to individuals in the group:

"It seems you all agree that your actions were reasonable given your past experience with hurricane warnings? And, that there wasn't a way you could have known that this one would be different. And, that John, had you attempted to evacuate at the time, you and the others might have been injured or killed."

6. Distribute and discuss Self-Talk and Affirmation Assignment.

Summarization and Goodbyes In the final session, leaders help participants to strengthen their new understandings by asking them to identify new insights, rehearse constructive attitudes, and think about implications for the future. Because loss and abandonment are trauma-related cues for many trauma survivors, it is important that group leaders directly address the experience of group termination for participants. In the last meeting, leaders allot an equal time for individual review (see description below), and facilitating a group discussion of group termination. In this way there is a discussion of both subjects during the final session.

1. Check-in.

2. Presentation of rationale for current session.

   "The purpose of our last session is to help you identify and summarize main lessons learned that can help you cope in the future, and to explore how we as a group feel about ending our time together."

3. Group member summarization of key lessons.

   Ask each member in turn to identify what he or she has learned in the group:

   - about ways of coping with stress and PTSD; about disaster memories;
   - about ability to deal with those memories and PTSD symptoms;
   - about future coping tools.

   Group discussion centers on these themes.

   "During our last meeting together, I am going to ask each of you to tell us a little about what you have learned about yourself. Especially, about how you have been trying to cope, how you plan to cope in the future, what obstacles you think might prevent you from continued good coping, and what your strategy might be to overcome such obstacles. I'll help you know what to tell us by asking questions. _____, how about starting."

   "What have been your main negative beliefs related to your disaster experiences? How are you going to challenge those beliefs in the future?"

4. Discuss group ending.

Ask members to express their thoughts and feelings about their group experience and about ending the group. Encourage them to take the view that the end of the group is the beginning of their work of learning to cope more effectively with PTSD-related emotions and life problems.

"Our group is going to be ending very soon. Let's talk today about what benefits you received from participating in the group, and what has not happened that you had hoped for. Also, how you feel about the group ending, and saying goodbye to everyone."

5. Check-out.

CONCLUSION

In this chapter, we have presented the rationale, procedures, and detailed session outlines for a cognitive-behavioral group treatment of disaster-related PTSD. It is important to note that this approach has been constructed from clinical experience, and remains to be empirically validated; hence, it should be regarded as a starting point for the development of group treatments for PTSD related to disaster exposure. We present the material because it is our observation that most of the writing and research on disaster mental health has focused on the acute phase of disaster recovery and on early intervention to prevent development of chronic postdisaster problems. Guidelines for treatment of PTSD once it has developed are also important. The approach outlined here adapts methods developed with other groups of trauma survivors, especially combat veterans, and is faithful to the principles and procedures currently employed in cognitive-behavioral treatments of PTSD. Specifically, it incorporates aspects of direct therapeutic exposure, cognitive restructuring, self-management skills training, and active problem-focused coping skills training to address some of the medium-term needs of disaster survivors with PTSD.

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APPENDIX 1. SELF-EXPOSURE TASK RECORD

Name _____ Date _____

Self-Exposure # _____

0 – 10 SUDs RATING

0 = no distress, relaxed
10 = as distressing as being in the traumatic experience itself

Please rate your personal ...

Distress at Beginning of Self-Exposure (0-10 rating): _____

Distress During Self-Exposure (0-10 rating): _____

Distress After Self-Exposure (0-10 rating): _____

What Negative Emotions did you have while doing the homework?

1. _____ 2. _____ 3. _____

What are the new ways of coping with your feelings which you are willing to do now?

1. _____

2 _____

3. _____

4. _____

5. _____

Thanks for filling out this homework form. Remember that by doing self-exposure as part of this group:

- You'll improve your ability to deal with your memories;
- You'll learn to handle strong emotions better;
- You'll begin to break the habit of isolating from others.

NOW, get some support if you need it, and do something active and positive to cope.

APPENDIX 2. LIST OF COPING STRATEGIES

Coping Strategies

Support-Seeking

- Call a friend and ask to talk.
- Get with family and talk.

Relaxation Exercises

- Progressive relaxation.
- Deep breathing.

Time-Out

- Walk away and calm down.

Journal

- Write about the situation and your feelings.

Self-Talk

- Be positive, remind yourself what you've accomplished.
- Be aware of negative distorted thinking.

Regular Exercise

- Walk, swim, bike, stretch, lift weights, etc.

Consistent Daily Routines/Rituals

- Awaken and begin day at same time; eat meals at regularly schedule times; plan recreational or self-care activities that happen daily, weekly or monthly.

Negative Thought Management

- Practice attentional focus and affirmation technique to increase ability to focus and refocus thoughts.

Self-Reward

- Find ways to reward yourself with small gifts, special time, etc.

Distraction through Positive Activities

- Play a sport, go fishing, go to a positive film, etc.

Support Group Attendance

- Go to a meeting.

APPENDIX 3. RECORD OF COPING

Coping with Symptoms

Name _____

Week _____

	Symptom	Situation	Negative Thoughts	Coping Thoughts/Actions
1				
2				
3				
4				

APPENDIX 4. MEMBERS' RELAXATION SKILLS PROGRESS LOG

Relaxation Log

Use this log to measure your progress with the two different self-relaxation techniques. Rate your level of tension/relaxation before and after each practice session using the following scale as a guide:

10	=	Absolutely tense	5	=	Slightly relaxed
9	=	Extremely tense	4	=	Moderately relaxed
8	=	Very tense	3	=	Very relaxed
7	=	Moderately tense	2	=	Extremely relaxed
6	=	Slightly tense	1	=	Absolutely relaxed

Δ = before

\+ = after

Example

10	10	10	10	10	10
9	9	9	9	9	9
8	8	8	8	8	8
7Δ	7	7	7	7	7
6	6	6	6	6	6
5	5	5	5	5	5
4+	4	4	4	4	4
3	3	3	3	3	3
2	2	2	2	2	2
1	1	1	1	1	1

5/26/M	____	____	____	____	____

Date/Technique
Technique: M = muscle; B = breathing;

10	10	10	10	10	10
9	9	9	9	9	9
8	8	8	8	8	8
7	7	7	7	7	7
6	6	6	6	6	6
5	5	5	5	5	5
4	4	4	4	4	4
3	3	3	3	3	3
2	2	2	2	2	2
1	1	1	1	1	1

____	____	____	____	____	____

Date/Technique
Technique: M = muscle; B = breathing;

Name: _____

APPENDIX 5. SELF-TALK AND AFFIRMATION TECHNIQUE ASSIGNMENT

Self-Talk Assignment and Affirmation Technique Worksheet

In a recent session we discussed how negative beliefs and distorted interpretations related to your disaster experience may perpetuate distress and impede your recovery. This assignment is designed to help you begin to counter the effects of negative or distorted thinking. Please set time aside to think about the questions listed below before using this worksheet to write down your answers. Bring the completed worksheet to our next session and be prepared to discuss your work. We will help you with any difficulties you might be having with the exercise.

1. After the group's discussion of common negative disaster related thoughts, are you able to identify any such thoughts you have? If yes, please write one or two thoughts down in a sentence.

   Example A: "*My kids will be scarred for life.*"

   Example B: *"I was helpless and I'd react that way again."*

Your thought(s): _____

_____

_____

2. Are you willing to view this thought (or these thoughts) as a negative belief or distorted interpretation of your disaster-related experiences that perpetuates your distress?

   Example A: *"Yes, I can see that my being afraid and my concern for my children's welfare has led me to worry excessively about the disaster's impact on them, and that my worrying all the time has got to stop."*

   Example B: *"Yes, I thought I was helpless, but it leaves me feeling unnecessarily worthless because it distorts the fact that I acted in a way that helped me and my family survive."*

_____

_____

_____

Self-Talk and Affirmation Technique Worksheet, p.2

3. Are you willing to believe that you can replace this thought with another thought to counter its negative effect?

   Example A: *"Yes, I can believe that most children are not permanently scarred and can go on to have healthy lives."*

   Example B: *"Yes, I can believe that I am not helpless, and there are countless ways in which I can help myself."*

4. What could you say to yourself to strengthen this counterbelief? Write down three sentences that reflect this counterbelief.

   Example A:
   1. *"Children are very resilient and often do well in spite of difficult experiences."*
   2. *"Many children do well in the long run after a disaster."*
   3. *"Giving my children a safe home and lots of love will help them feel secure."*

   Example B:
   1. *"I am not helpless."*
   2. *"I help myself all the time."*
   3. *"I can help myself get over what I interpreted as helplessness."*

5. Summarize the three sentences into one sentence.

   Example A: *"My children will be all right with love and support."*

   Example B: *"Helping myself is an act of not being helpless.*

Self-Talk and Affirmation Technique Worksheet, p.3

6. Select from the above sentence, two-to-eight words that represent the sentence's affirmation.

   Example A: *"With love and support my children are well."*

   Example B: *"I help."*

Please write down your affirmation: _____

_____

_____

7. Divide this affirmation (phrase) into two or three parts.

   Example A:

   Part 1: *"With love and support"*; Part 2: *"My children are well."*

   Part 1: *"With love"*; Part 2: *"Support"*; Part 3: *"My children are well."*

   Example B:

   Part 1: *"I"*; Part 2: *"Help."*

_____

_____

8. Next, practice one of the relaxation techniques you have learned. Immediately afterward (while in a state of relaxation) try repeating the sections of the phrase you wrote down in question 7, selecting Part 1 to focus on during a deep inhalation and Part 2 on a long steady exhalation. If phrase is divided into three parts, the middle part becomes the focus of thought during the two-second holding of breath between inhalation and exhalation. Practice for five minutes several times over the next week and be prepared to discuss your experience at the next session.

   Example A:

   Inhalation: "With love and support" — Hold 2 sec. — Exhalation: "My children are well."

   Inhalation: "With love" — Hold 2 sec. "Support" — Exhalation: "My children are well."

   Example B:

   Inhalation: "I" — Hold 2 sec — Exhalation: "Help."

Self-Talk and Affirmation Technique Worksheet, p.4

9. Describe an actual situation that would be an opportunity to recall your affirmation.

   Example A: *"My children are misbehaving, and I remind myself that their behavior isn't the result of the earthquake. I remind myself that they are healthy kids who sometimes just misbehave."*

   Example B: *"I am feeling overwhelmed by how much I have to do to restore the house to what it was before the earthquake. I remind myself of how much I have done already and of the fact that I am helping my family return to normalcy."*

   _____

   _____

   _____

   _____